(Reese T. Jones) December 5, 1985 A.M. Session

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SANTA BARBARA

DEPARTMENT NO. 2 HON. BRUCE WM. DODDS, JUDGE

ELAYNE D. GALBRAITH, et al.,

Plaintiffs,

vs. No. 144417

R. J. REYNOLDS TOBACCO COMPANY, et al.,

Defendants.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

December 3, 4 and 5, 1985

APPEARANCES:

For Plaintiff: LAW OFFICES OF MELVIN BELLI
BY: MELVIN BELLI, ESQ.
PAUL MONZIONE, ESQ.

For Defendant R. J. Reynolds: LAWLER, FELIX & HALL
BY: THOMAS WORKMAN, ESQ.
F. JOHN NYHAN, ESQ.

and

ARCHBALD & SPRAY
BY: DOUGLAS LARGE, ESQ.

and

ROBERT WEBER, ESQ.
Pro Hac Vice

Pages 1402 through 1781-82

NORMA JEAN WINDORTH, CSR NO. 2906
Official Reporter
Courthouse
Santa Barbara, California 93101

case. We'll, just like other things, have to delete that.

THE COURT: You can do whatever you want.

MR. BELLI: I want that so your Honor won't accuse me of bad faith like you did the other day.

THE COURT: I understand very well. We'll take about ten minutes and get the jury in.

(RECESS)

(Whereupon, the following proceedings were held in open court within the hearing and presence of the jury:)

THE COURT: Good morning, ladies and gentlemen.

It's my understanding that the jury had a big party because Mrs. Anderson and Mr. Dotts had a birthday. They didn't invite counsel or the Court.

JUROR DOTTS: It's an all-day affair.

MR. BELLI: We can sing.

THE COURT: Are you ready to proceed, counsel?

MR. BELLI: Yes. We have Dr. Reese Jones, if we may.

Doctor, would you please step up and be sworn.

REESE T. JONES,

called as a witness for and on behalf of the plaintiffs, having been duly sworn, testified as follows:

THE CLERK: You do solemnly swear that the testimony you are about to give shall be the truth, the whole truth, and nothing but the truth, so help you God.

THE WITNESS: I do.

THE CLERK: Please be seated and state and spell your

name.

THE WITNESS: The name is Reese T. Jones. First name R-e-e-s-e. T. Last name Jones, J-o-n-e-s.

DIRECT EXAMINATION

BY MR. BELLI:

Q Doctor, I am going to question you so everybody will know I am still in the case.

I want to ask you first about your curriculum vitae. This shows where you went to school and everything about you professionally.

So, let me ask you: Where did you take your premed studies?

A I trained at the University of Michigan in experimental psychology.

Q What is experimental psychology?

A To try to understand what motivates, what governs people's behavior, how they think, how they learn and react.

Q And what are you doing now and where?

A I am -- for the last twenty-five years have been at the University of California, San Francisco, the Medical Center, I am currently a professor of --

Q You are a faculty professor there?

A Yes.

Q Do you have your own private practice?

A I see occasional consultations, but I am full-time teaching and research.

Q What field?

A In the field of psychopharmacology.

Q How about "pharmacology," what is that?

A Pharmacology is the systematic study of the effects of drugs on the organism.

Q Did you have any professional formal training in pharmacology?

A Well, in medical school, one gets a number of courses in pharmacology.

In addition, through my four years of medical school, I spent elective periods, summer, working full time in a pharmacology laboratory, studying the effects of psychoactive drugs.

Q Were you on the Federal Drug Administration's committee with reference to some nicotine gum?

A I served on the Food and Drug Administration committee on drug abuse, which was the committee that just happened to review the clinical material associated with Nicorette gum.

Q Nicorette?

A Nicorette. N-i-c-o-r-e-t-t-e.

That is the first marketing of nicotine as a drug as opposed to dispensation in tobacco --

THE COURT: Mr. Belli, you're stepping all over the witness. Let him finish the answer.

MR. BELLI: I am sorry.

THE COURT: Are you through?

THE WITNESS: Yes.

Q BY MR. BELLI: Is that the same nicotine in

cigarettes.

A It's identical to the nicotine in cigarettes.

Q Is that gum addictive?

A In the package insert, the warning that is given to patients and also to physicians prescribing the gum are advised to give a warning that it's an addictive, habit-forming, dependence-producing substance

Q Is that the same type of nicotine in cigarettes?

MR. WEBER: Objection: It was just asked --

THE COURT: Sustained. It was asked and answered.

Q BY MR. BELLI: Let me ask you about some of your positions and appointments so we'll learn a little bit more about you.

How about the Philadelphia General Hospital, did you do anything there?

A That was a rotating internship in a very large big city, general hospital.

Q Were you an assistant resident at the University of California Medical Center in San Francisco?

A I have had all of my residency training in psychiatry at the University of California, yes.

Q How about the Langly Porter Neuropsychiatric Institute in San Francisco?

A That is the specialized institute at the University of California where the psychiatric treatment and research is done.

Q You're on the full-time faculty at the University of California, the medical school?

A That's correct.

Q Did you do anything ever with the Food and Drug Administration Abuse Advisory Committee?

A Well, that is a committee of people who are thought to be knowledgeable in the area of how -- what determines the abuse liability, the addictiveness of drugs, and our task was to review new drugs that were considered for marketing as to what their addiction potential would be.

I served on that committee for a few years.

Q Are you still on that?

A No, I rotated off after four years. I am no longer on that committee.

Q What do you mean, you "rotate off"?

A Sometimes rotate back on, is what I mean by rotate.

Q Veterans Administration Merit Review Board.

Are you on that?

A I just finished a three-year term of duty on that review board.

Q How about the National Research Council, Committee on Toxicology?

A That was another committee where I was appointed as an expert to review the psychoactive effects of a variety of psychoactive drugs. That research was done some years ago by the U. S. Army.

Q Did you ever have anything to do with the National Academy of Science Instutite of Medicine?

A There was a committee, which I was a part of that

body.

Q Did you have anything to do with a drug abuse research grant with the National Institute on Drug Abuse?

A Well, my major time has been spent, for the last twenty years, on a variety of research grants on drugs of abuse, all supported by the National Institue on Drug Abuse.

Most of it has been the last ten years, where I directed a clinical drug research center sponsored and funded by the National Institute on Drug Abuse, where we focus on drugs like cocaine and tobacco and opiate drugs -- morphine, heroin -- and other drugs that are considered to present problems in terms of people's habitual addictive abuse of it.

Q Did you have any tour of duty with the United States Public Health in the --

A I spent two years -- my tour of duty consisted of two years working at the National Institute of Mental Health back in 1959 through the '60's. They were just beginning what was called then the Psychopharmacology Service Center, which now has grown into the Psychopharmacology Research Center, which has been the main body that encourages, stimulates, funds studies and research grants in the area of psychopharamacology and drugs.

Q When you put psychopharmacology together, what does that entail; what do you do?

A Psychopharmacology is focusing on the classes -- the pharmacology of classes of drugs that primarily affect mood, thinking, sensation; that is, brain events as, say, compared to cardiovascular drugs, which would mainly be

heart-affecting drugs or renal drugs.

It's trying to deal with, trying to measure, trying to determine the mechanisms of drugs that affect the mind as opposed to drugs that might effect some other organ system.

When I say "the mind," I generally mean the brain.

Q Do you see private patients?

A Very rarely do I see private patients. As I said, I am full time in teaching and research.

Q Do you see patients for the university?

A I see patients in consultations as part of my position as a professor at the university where, if a junior staff member has a problem, usually in the area of drug dependancy on psychopharmacology, I will often consult on that by virtue of my activity as a university professor.

Q Let me jump ahead so I can ask the next question.

Do you have an opinion as to whether the tobacco smoke in the cigarettes that we have on the market today is addictive?

A I think there is absolutely no question that it's the prototype of an addicting drug.

Q What do you use to base your opinion on?

A To summarize, it's my experiences, in the last eight years, where we are -- our group that I am associated with has probably the most extensive, broad-based tobacco research program active in the United States right now. It's based on authoritative textbooks of medicine, Cecil's Textbook

of Medicine. This just came out a few months ago.

Q Let me ask you about Cecil.

Is Cecil's the leading textbook on medicine and has been for years?

A It's one of the Bible's, one of the greats in medicine. It's one of the highly authoritative texts that every physician would refer to as an authoritative statement.

Q What do you rely on in this with reference to cigarette smoking being addictive?

MR. WEBER: If there is a recitation of what is in the book, I think it's improper.

THE COURT: The way the question is phrased, it's proper.

Q BY MR. BELLI: Just don't give us all the book.

THE COURT: What did you rely on, Doctor?

THE WITNESS: Well, in Cecil there is the statement that tobacco and nicotine are, again, quite typical of drugs that are considered to be addicting.

I also rely on a chapter in Goodman and Gillman's textbook of pharmacology, which is another one of the Bibles in medicine, one of the books people would take to a desert island, if they only had a choice of two or three books, and had to practice.

Q BY MR. BELLI: Would you take one of mine along, too? I shouldn't say that.

A There is a whole host of the Surgeon General's reports that have been issued over the years from the National Institute of Health; at least ten reports I am familiar with

in detail issued by the National Institute of Drug Abuse over the past ten years or so.

Reports from the Royal College of Physicians.

Q Where is the Royal College of Physicians?

A It's a British organization somewhat equivalent to our American Medical Association that conclude quite unequivocally that tobacco is an addicting drug.

THE COURT: Mr. Belli, Mr. Weber. May I see you a moment.

(Side bar conference not reported.)

Q BY MR. BELLI: I asked you a question a moment ago about whether cigarette smoking was addictive in your opinion. You answered that, and you said something about -- it was a compound answer -- nicotine and tobacco.

What do you mean? Do you distinguish --

A Well, in discussing, particularly, issues related to addiction dependency and so on, things are very complex when you talk about tobacco, because tobacco is a complex mixture of drugs, and it's hard to separate certain effects of tobacco from the effects of learning and things people read and see in the milieu around them.

On the other hand, if you focus in on nicotine -- that is the pure substance that is in tobacco; that is probably the most important pharmacologic reason why people use tobacco, then things become a little simpler, because nicotine you can measure, you can put it into animals easily, where you can't put tobacco into animals easily. There is a host of experiments one can do about nicotine rather than

tobacco.

The reason I use the two terms together is that my feeling, and the feeling of almost everyone that I know who is heavily involved in psychopharmacological research of tobacco is that one can transfer most of what we know that controls the use of nicotine and transfer it to what controls the use of tobacco.

If you just keep in mind that one is a very simplistic -- i.e., nicotine; and one is a very complicated mix of thousands of things, tobacco -- I have to be careful. I will slip back and forth sometimes talking about nicotine, sometimes about tobacco, because that is the way we conceptualize this right now.

Q How about these animals studies you say that they have done with reference to nicotine.

What are they?

A Nicotine seems to be rewarding to an animal; that is, what I mean by that is animals will self-administrate it as if they want it. This is one of the operational definitions of a drug that has abuse liability.

That is, if you set up a situation where the animal has a choice of administering it, whether he administrates it or not. And drugs like cocaine, hercin and other opiates, drugs like alcohol and drugs like tobacco -- i.e., nicotine -- animals will self-administrate quite actively.

Q Do you have an opinion, medically, as to why they do that?

A Well, I have to express my opinion with the bias of a human researcher that, probably, because they like it; that is, anthropomorphizing.

Who knows what goes on in a monkey's head, a rat's head. I prefer to do similar experiments with humans. I ask, "Why do you use nicotine?" I don't do animal studies. I do human studies.

Q How do you compare nicotine or cigarette smoking as being addictive with cocaine and heroin?

A It's always hard to compare just what drug is more addictive than any other drug because issues like availability and information about the use of a drug, et cetera, determine a drugs addictiveness as well as the pharmacology documents.

There is a fair amount of data that only a psychiatrist could get, a pharmacologist wouldn't get. I am trying to defend my position: Why is a psychiatrist doing this?

This is, if you take people addicted to heroin and tobacco, or if you take people addicted to alcohol and tobacco, or if you take people who are addicted to cocaine and tobacco, and you somehow by treatment eliminate their heroin addiction, eliminate their alcohol addiction, eliminate their cocaine addiction, that is hard to do. But it's easier than eliminating their tobacco addiction.

If you go to a heroin clinic where people are on methadone or clinics where they are not on methadone, people that have stopped using those substances still using tobacco.

If you go to some alcoholic institutes -- the traditional AA group people have successfully gotten their alcohol addiction under control. They are still smoking.

The same for cocaine in our experience.

Ask the heroin addict or the alcoholic, "Why don't you stop smoking? You were able to stop using heroin. Your were able to stop using alcohol." Almost invariably the answer is, number one, "My God, what kind of sadist are you to force me to give up my last pleasure."

Number two, "I can't stop it. Yes I can stop the coke. Yes, I could stop the heroin. I can't stop smoking."

Q That brings us right down to the area of freedom of choice, which is so dear to us in this country and all over the world. It should be.

Do you have -- in your opinion, as a pharmacological and psychiatric worker, do you have a freedom of choice of stopping nicotine?

Are we all the same in that regard. Are we able to --

MR. WEBER: I object. I am not sure I understand the question, your Honor. There were about three of them tied together.

THE COURT: I am not sure I understood it either.

MR. BELLI: I withdraw.

Q BY MR. BELLI: Do we have a freedom of choice in stopping nicotine?

MR. WEBER: I object to the incomplete nature of it. Who does the "we" refer to, an average person; what is it?

THE COURT: I assume you're referring to an average person?

MR. BELLI: Yes.

THE COURT: Hypothetical person?

MR. BELLI: Yeah.

THE COURT: All right.

With that understanding, go ahead.

THE WITNESS: Well, to give, you a -- to narrow my answer down to, say, let's consider someone who just smokes two packs or three packs a day of tobacco, cigarettes, and has been doing such a thing for forty years or so, and has good reason to stop. to give a yes-no answer --"Does that person have freedom of choice?" -- sort of ignores the whole philosophy of free will, and what determines one's ability to determine one's destiny. I have to give it a little indirect.

Number one, the person who has been smoking two or three packs a day of cigarettes, and -- to make it simple, two packs day -- is getting four hundred doses of nicotine a day.

Q How do you figure that?

A Each cigarette, on average, someone would take ten puffs, sometimes twelve, ten on an average.

Each puff -- the way nicotine works as a drug, each puff, really, the only way you can consider, is a single dose because the smoker adjusts each puff as it goes from the lungs to the brain.

If someone is doing something like that seven hundred times a day or more, seventy, eighty thousand times a

year -- if you're a two-pack-a-day smoker, over a hundred thousand times a year -- what does it take to stop that? Well, it's more than just making up one's mind and saying, "I am going to exercise free will and stop."

What has happened is there is all sorts of an adaptive processes going on that the body, the brain sets up to compensate for the presence of the smoke and the nicotine.

Q Can you stop right there and tell us a little more about that specific subsection.

A lot of an adaptive processes that are going on,

Let me ask you with reference to is that body chemistry or what?

A I am referring to body chemistry.

Fairly complicated neurochemical changes from the little -- bolus is the term we use, these loads of nicotine that seven seconds after one takes a puff in the lungs, it hits the brain; it triggers the release of all sorts of hormones, endorphins, probably adrenalin, things that make people feel good and feel happy.

Now, there is all sorts of mechanisms in the body that try to counterbalance this. The body tries to maintain a state of -- homeostasis is the fancy word.

Q What does that mean?

A If a drug changes some system in the body, the body's mechanism tries put things back the way they were.

There is all sorts of adjustments going on to keep the blood pressure that goes up after smoking to make it go down; to make the mood elevation, the increase in the

tension, the good things about nicotine, which there is a lot of them, there is all these other mechanisms that suppress it.

When you take away the nicotine -- if the smoker says, "I have had it. I have stopped." It's as if these adaptive mechanisms -- I am summarizing a host of them -- these adaptive mechanisms have nothing to work on when you take away the nicotine. It's as if they are running wild.

If, instead of getting relief from an irritable, hostile, short-tempered state as the nicotine does, when you take away the nicotine, the person become irritable, short tempered, impatient, depressed, headachy, sleep disturbances, and bowel disturbances.

You can say, "Free will is free will. I will put up with this a couple of days, and it will go away." There are other forces that make it very, very difficult to do. Friends around are smoking. You're working in an office where someone says, "Oh, have a cigarette. You look awfully irritable. You look hostile. You're difficult to live with. Have a cigarette."

Everywhere one looks in the environment one sees information that people tell you, people let it be known there is good things about smoking. You're missing them all because you gave this up. So, you have this deranged internal state which is really basically, chemically determined with all these psychological factors, social factors, economic factors, all sorts of other things all conspiring to sort of force this person back into smoking again, which makes the whole issue of it's sort of free will depending on what?

Free will works fine even for someone who is addicted, three-pack-a-day smoker for thirty-five years, smoking high nicotine-delivery cigarettes if that person is working in a smoke-free office, if they have just had a romantic involvement -- is in an intense one with someone who hates smoking -- if some doctor says, "You have a spot on your lung; and, if you stop smoking it will go away"; and if you don't hear any positive messages from anybody about the joys of smoking, then you can exercise free will and it will work.

I apologize to the Court, and perhaps to the jury for taking so much time. But I think it's a basic question you ask that is very difficult give a simply direct answer to.

Q Let me ask that question with reference to cocaine and heroin.

Do you have the same chemical interdependency with reference to the body's chemistry as you do with smoke?

A There are many similar neurochemical adaptations that go on with both heroin and cocaine.

There is one enormous difference that is outside the area of chemistry between cocaine and heroin and tobacco. It is that, with heroin, there is a hundred thousand addictions -- at the most, a hundred fifty thousand. Maybe there is another, on the outside, another million people using heroin.

So, if you are a heroin addict who tries to stop, it's hard to get the heroin. There is fewer people around you, particularly if you move from the neighborhood and go someplace else where there are fewer people, who say, "A shot

of heroin is not so bad."

The same thing, to some extent, with cocaine. It's harder to get cocaine than tobacco. It's easier to get away from the cocaine scene than it is with tobacco.

When you compare those two drugs with tobacco, there is fifty-five million users around. It's probably easier to obtain tobacco than any other substance, next to water, known to man. Any hour of the day or night, you can buy cigarettes. You can't always get food, or sometimes even a drink of water. For the person trying to quit, there is tremendous difference between heroin, cocaine and nicotine tobacco.

In response to that earlier question, what is more addictive, I suppose, if heroin, cocaine and nicotine were equally available, then we could better test that out. That is being done in laboratories. We may want to review that data.

Other than that, you have all these other social, economic, environmental things around that distort just what is going on chemically in a person's head after the drug is stopped. You have to consider the whole picture.

Q Have you done any lab work, electroencephalograms, x-rays with reference to someone smoking and see there if is an actual change in the chemistry in the body with reference to smoking?

A We and a number of investigators have recorded brain waives, EEG's, which is one very traditional index of changes in brain activity and brain function.

We find that, if you take someone who is using two packs a day of cigarettes regularly, don't let them smoke for twelve hours or so, their brain waves, particularly their natural rhythms slow down, give a picture electrically of someone who is a bit sluggish, blah, depressed. It's consistent with that state.

Give them some nicotine, either by smoking in a cigarette or more precisely by injecting it into their arm or in the form of Nicorette gum or others, given as an aerosol or as an oral tablet -- anyway, you give the cigarette or nicotine; you see an immediate, within seven, eight, ten seconds after it goes in -- smoking, longer, orally -- you see an immediate altering of the brain wave.

The alpha active which was sluggishly going along at eight cycles per second goes up to twelve. Subjectively, mood-wise, the subject says, "I feel better. I feel more alert. I am less irritable," et cetera. They can give this on various rating scales.

This indicates, so far as you can do electrically, that here's the drug going from lung to brain. The electrical changes change at about the time the mood changes occur. For those who need that sort of documentation, it's there on paper.

Q Let's take someone -- I ask if you have an opinion, that this man would be addicted who has been smoking since he was fifteen --

MR. WEBER: Objection, your Honor.

THE COURT: Sustained.

Approach the side bar.

(Whereupon, the following proceedings were held at the side bar outside the hearing of the jury:)

THE COURT: Mr. Belli, I told you specifically not to have this witness talk about Galbraith.

MR. BELLI: He's not going talk --

THE COURT: He's going to talk about somebody who was fifteen years old --

MR. BELLI: Took the cannula out and smoked.

THE COURT: That is not Mr. Galbraith?

MR. BELLI: If it weren't Mr. Galbraith, then the question would be incompetent, irrelevant and immaterial; the hypothetical assumes facts not in evidence.

THE COURT: You specifically violated the Court's order again.

MR. BELLI: Judge, I just don't understand you.

THE COURT: I am sorry you don't understand me. I do understand you. I want you to abide by the Court's order.

MR. BELLI: I resent that, Judge.

THE COURT: You can resent it all you like.

MR. BELLI: I know, and I do.

THE COURT: You were specifically instructed not to ask this witness about anything concerning Mr. Galbraith. You started to do so. Do not do so.

MR. BELLI: I asked generally, "A man that smokes..." --

THE COURT: You were here this morning.

MR. BELLI: That is what I did.

THE COURT: I don't know how you could not understand.

MR. BELLI: Would your Honor tell me what I can ask with reference to a man that smokes two packs of cigarettes a day --

THE COURT: You can say, "If a person is a heavy smoker, are they addicted?" It was what we discussed for fifteen minutes.

MR. BELLI: Well, "Taking the cannula out and smoking, is that addiction?"

THE COURT: You cannot --

MR. BELLI: Jesus, Judge --

THE COURT: You cannot say anything about Mr. Galbraith.

Do you think I am an idiot? Do you think the jury is an idiot? Do you think they won't make that connection?

MR. BELLI: I don't think the jury is an idiot.

THE COURT: The implication you think I am is accepted.

MR. BELLI: Judge, I understand that I can't ask a question about a man is a heavy smoker, two packs a day; started smoking when he was fifteen; and then, when he was sixty-nine, he had cancer.

THE COURT: I am going to only say this once, and we're going to go back there: Mr. Belli, you're not to ask any questions and the witness is not to say anything -- I think the witness understands -- relating to Mr. Galbraith or relating to the facts of this case, period, end of order.

I said that specifically this morning.

MR. BELLI: Will your Honor tell me so I won't violate the order, can I say, "If a man is a heavy smoker with two to four packs a day, is he addicted." Can I ask that?

THE COURT: You may.

MR. BELLI: Then can I go further and say that he's been smoking since his early age?

THE COURT: You may not. You seem to want to walk beyond the line no matter where it goes. I am going to make you stay a little further in the line.

You say if a person is a heavy smoker for many years -- which has already said forty years, which certainly seems to imply Mr. Galbraith, which I noted at the time.

I am sure you did, Mr. Weber.

MR. WEBER: Yes, your Honor.

THE COURT: The attempt to circumvent the Court's orders is just getting really annoying. You will not say anything that indicates that this witness is relating his testimony to Mr. Galbraith, because he did not do anything in that regard at the time of the deposition.

This is the third witness we've gone through on this. Why we do it each and every time is beyond me.

Let's proceed.

MR. BELLI: Can I ask if a man is told not to smoke, and he has a terminal illness and he continued to smoke, if he's addicted?

THE COURT: Mr. Belli, are you telling me you don't believe that what you just asked me relates to Mr. Galbraith?

MR. BELLI: Yes, but I can't mention the facts of Mr. Galbraith's terminal illness?

THE COURT: That's right. Because this witness didn't know anything about the Galbraith illness at the time of the deposition.

Let's proceed.

MR. BELLI: I can't -- never in my life, Judge --

(Whereupon, the following proceedings were held in open court within the hearing and presence of the jury:)

MR. BELLI: Doctor, there are a number of people who stopped smoking, as well as a number of people who stopped heroin and cocaine.

Is that true?

A That is quite true.

Q Does that make the three any the less addicting.

MR. WEBER: Objection to the leading, your Honor.

THE COURT: Overruled.

THE WITNESS: No.

By the very definition of addiction, you don't know whether you have an addiction unless someone has tried to stop, and part of the definition is you stop and you relapse. The fact that people stop addictive drugs in any way is contrary to the notion that they are addicting drugs.

Q Do you know if there is any statistics as to how many people have stopped smoking then started again, stopped and started again?

A I know of no good authoritative large sample

statistic.

I know, from our experience in our laboratory with six hundred patients who have come through a tobacco treatment clinic and probably two hundred patients who have been in other experiments, on average, these patients have tried to stop four times.

Now, in general they are adults, thirty years old. So, the numbers of times would depend on the age and all sorts of things. Certainly, four or five times trying to stop, restarting is more typical of the tobacco smoker than the exception, and the same is true of the other drugs.

There is multiple reports from a subject: "How many times have you tried to stop?" "Oh, a dozen times."

Q What does that have to do with the question of free will, the right to choose if you stop smoking and then you start in again; what is it that makes you start in again?

A What -- it's no simple answer to all the factors that make you start in again.

Q Is there something?

A Well, yes. There is no question. It's an application of the pharmacologic factors I alluded to, the social, The psychological forces, the experiential things that surrounds any addict, smoker or otherwise.

Q Do some people in the clinic have an easier time stopping; and, if so, why?

A There is a difference in all addicts how easy it is to stop. You have to remember in a clinic situation where the best data come from -- by definition, these are the people

who have had the most trouble stopping who come to a clinic, pay money, go through paper work to get treated. They couldn't stop themselves. They are people, whether because of motivation, because of a different genetic background, or different body chemistry or different friends, or different newspapers they read, or different activities they participate in, they have more trouble quitting than the people who don't come to the clinic.

I know a lot about the six hundred who come to a clinic and other tobacco treatment clinics. Nobody knows about the millions of people who quit on their own, particularly how often they quit, how often they went back to smoking, what made them go back and all these things. These are virtually -- they are unanswerable questions right now.

Q Do you think cigarettes should be banned, cigarette smoking?

A If by "banned," you mean some legal prohibition --

Q Yeah.

A I don't think so, no.

Q You don't think so.

How about the genetic response in smokers, are some people different than others? -- just enlarging on what I just asked you.

A There are great differences in people for reasons for smoking, and the way their autonomic nervous system reacts when you give them tobacco smoke or nicotine. This is just beginning to develop as an area of research. It's well known

that a population of smokers in general tend to be extroverts rather than introverts.

They tend to be what is called by the psychologists sensation seekers, thrill seekers. Their outlook being for things rather than being conservative and not looking for new sensations.

This is not only sensation in the sense of going to Disneyland, but sensations in food and eating and everything else. They tend to be Type A-type people, more driven, more active rather than contemplative B-type people who are relaxed and laid back.

The issue has always been: Did the tobacco use cause that or were they different to begin with. That is sort of a basic issue. That answer is sometimes undetermined. It's probably a little bit of both.

It was probably a predisposition for those who start smoking three packs a day. That has to do with some wired-in genetic sort of predisposition, I would bet. But that is the nature of humankind. That is the nature of people, all drugs and all things.

I think that is probably one thing that medical science has really nailed down in recent years: that there is a lot of wired-in potential in all of us. But whatever the genetic wired-in potential is, all these forces, what you're told about tobacco, what you believe about tobacco, what your dearest friends tell you about tobacco, who you live with, who you don't live with, all are just as important -- and I think far more important -- than the genetic whatever neurochemical

quirk might be different because they are so pervasive.

Q Do you have any figures and percentages on those who are unable to quit who tried?

A Well, every survey that I am familiar with, certainly in the last ten years, that has asked populations of smokers, "Why do you smoke? Do you want to smoke?" the majority of responses has always been more than fifty percent, sometimes as high as ninety percent say, if they could quit, they would stop smoking.

A partial answer to your question, fifty to ninety-seven percent of smokers asked say, "I would quit if I could."

Now, if you say, "Why do you want quit?" then the answers get rather complicated, and it's hard to summarize.

Most smokers for whatever reason -- I wish I understood why; I probably would get a Nobel prize -- when asked, say, "If you could stop smoking," -- this is not in the teenage years; in the twenties and thirties -- most smokers when asked, "Would you quit?" they always say yes,

What the difference is is in the smoker --

MR. WEBER: I object to the narrative answer. It's nonresponsive.

THE COURT: Sustained.

Q BY MR. BELLI: Doctor, has there been any studies of taking nicotine out of cigarettes and what happens to people who are then given those cigarettes?

A People will not consistently, willingly or happily smoke cigarettes that don't contain nicotine. People

with difficulty can learn to smoke cigarettes that deliver low amounts of nicotine; but no one, to my knowledge, will consistently smoke tobacco that has no nicotine in it.

Q Did you do some work with the National Drug Abuse Center?

A Well, our work is supported by the National Institute and Drug Abuse Center. We and others at their Addiction Research Center are doing similar experiments.

MR. WEBER: The question was whether they did work for them.

THE COURT: Sustained.

Q BY MR. BELLI: Your answer has been given?

A The answer is, yes.

Q Do you rely on what they are doing with reference to nicotine cigarette smoking being addictive?

A I think the work done at the Addiction Research Center supported by the National Institutes of Health is right at the cutting edge of what is known about tobacco addiction.

Q Do you have an opinion, if I just gave you the bear fact of someone smoking two, three packages a day, would that bare fact itself shows addiction, or do you need some more than that?

A To be -- to give a purist answer, one would have to know had they ever tried to stop. I would find it almost inconceivable that someone who is smoking two and three packs a day regularly, who is an adult, would not have a very marked element of tobacco addiction.

MR. WEBER: I would like to object and move to strike

the answer as nonresponsive.

The question was would that person be addicted?

THE COURT: Overruled.

Q BY MR. BELLI: How about eggs, potato chips, Tutti-Fruitti bars, and all these things, junk food, are we addicted to that?

A The answer is no, in that the classical, traditional concept of addiction applies to drugs and food and potato chips and eggs -- if you're worried about colesterol -- are not drugs. They are foods.

The behavior is superficially similar if you do a lot of something people say you should not do and you should stop; but; in the superficial sense; it's same thing. It's rare that a potato chip eater is doing something equivalent to two hundred doses of something a day. If you're a pack-a-day smoker, you spend five hours a day doing nothing but smoking.

I guess I would have to answer that in a potato chip eater compulsively does nothing but eating potato chips for five hours of their working day, maybe there are some similarities.

Q When you say doing nothing but that, what do you mean?

A Going through the ten minute ritual of finding the cigarette, light it up, to taking the ten doses of nicotine, to finding someplace to put it out. That is a terrible waste of the time.

That's where the simple analogy is. Breaking down the definition of addiction, you should emphasize it's

the compulsive drive in overinvolvement with something. To my knowledge, the usual models that you cite, you don't have that element of compulsive involvement, need that you see quite typically in the tobacco smoker.

Q How many doses a day of nicotine and the other components in cigarette smoke does a two, three-pack smoker get?

A Between two hundred -- if it's two-pack-a-day on average, two hundred doses and three-pack-a-day on average would be four hundred doses a day every day.

MR. BELLI: You may cross-examination.

Thank you, Doctor.

CROSS-EXAMINATION

BY MR. WEBER:

Q Doctor, some questions were asked about the number of persons and what data you knew about the number of persons who quit smoking and ordinary ability to maintain that; do you remember?

A Yes.

Q You stated you didn't have complete authoritative data and went on to explain, did you not?

A Yes.

Q One thing you do know is that thirty-five million people have quit smoking and not gone back; isn't that right?

A I have heard that figure was raised at the deposition your firm took from me. I have seen it either three million, thirty-five million at various places.

But, when I say "authoritative," for the last month, I have read through, now, eight hundred publications related directly or indirectly to tobacco dependency. That figure keeps coming up, but nowhere do I find an authoritative source of the data that makes up thirty-three million out of a population of what? Over twenty years time, how many people were smoking in the twenty years. It's an a mythological figure. It sounds enormous. Three million is a big number. Three million out of what. Maybe you know. I don't.

Q My question was you know and agree that thirty-five million people have quit smoking and not gone back. Isn't that true?

A I am sorry. I said I don't know.

That is true, because I don't ever -- I have never been able to find the source. Everyone quotes everyone else, but no one gives a study.

Q Let me read from the deposition page 35 to 36 starting at line 27.

THE COURT: Give counsel an opportunity to look.

MR. BELLI: Go ahead.

Q BY MR. WEBER: (Reading:)

"Q Do you agree there are 35 million people in America who have quit smoking and not gone back?

"A Sure. You know, I won't quibble about a few million here or there. Yes, it's a good number."

Q Now, Doctor, you also mentioned different

international groups during the course of your direct examination, did you not?

A Yes.

Q You spoke about how they supported your feeling that tobacco is an addictive substance, correct?

A Yes.

Q You didn't mention the World Health Organization, did you, Doctor?

A I did mention it. I thought I did.

Q Doesn't the World Health Organization hold that tobacco use is a non-dependent use?

A I was at a meeting two years ago in Copenhagen where we were discussing the world health diagnostic classifications, and tobacco dependence was one of the major issues discussed there.

Q Doctor, doesn't the current international classification of diseases by the World Health Organization establish certain categories for drug dependence?

A That's right.

Q Tobacco use is not classified in drug dependence is it?

A It is in ICD-9.

Q How about this one that says "ICD-9" on the front.

Is that the one you refer to?

A Yes.

Q Isn't the use of tobacco classified as a non-dependent use?

A What does it read?

Q Do you know one way or the other?

A No, I don't. I may be wrong on that thing.

Q So, you, as one who spent his life studying on this for the past twenty years, don't currently know as you sit here today what the World Health Organization classification is for the use of tobacco?

A It's one of the twenty thousand facts that I mentioned this morning that was wrong.

Q Now, you also made some comparisons between opiate drugs and tobacco, didn't you, Doctor?

A Yes.

Q The fact of the matter is that even if tobacco is viewed as a drug, it's not like the opiates at all with respect to the whole topic of withdrawal, is it?

A I would disagree quite vehemently and vigorously.

MR. WEBER: Page 43, Mr. Belli, lines 16 through 20.

MR. BELLI: Object to that: There is nothing in impeachment.

THE COURT: There is an objection?

MR. BELLI: Yes.

THE COURT: May I see it?

(Side bar conference not reported.)

THE COURT: I will allow the material to be read.

Counsel, go back to the other material to explain that phrase.

MR. WEBER: Could I have the question and answer again that preceded the side bar, your Honor.

THE COURT: You may.

MR. WEBER: Starting at line 3 on page 43:

"Q I take it you would agree that you certainly couldn't do that with a tobacco smoker?

"A Only because opiates are a very unusual class of drugs where there is a specific antagonistist that immediately and abruptly turns on the effects off the opiates so that you can, in a sense, magnify the intensity of the withdrawal symptoms.

"With tobacco, and with no other drugs, we don't have any antagonist.

"But, if we had an antagonistist, theory would predict, the pharmacology of nicotine would predict, you would be able to do that. But, we don't have it."

"Q If I understand your answer, you would agree that tobacco is not like morphine in that regard?

"A No other drug is like morphine. Of the thousands of drugs, morpines or opiates, stand out alone."

A You're taking a section --

THE COURT: There is no question pending.

MR. BELLI: You're not reading the rest.

THE COURT: You may not have an opportunity.

THE WITNESS: It's not my complete statement.

THE COURT: I understood that. You have an

opportunity --

MR. BELLI: I am just cooling him to you Judge not you.

THE COURT: Mr. Belli, you'll have an opportunity to do something later.

Q BY MR. WEBER: Doctor, you don't doubt that was the question and answer, do you?

A I said what you said there. It's what is on the preceding page that is important.

Q Doctor, you went through your deposition recently, did you not?

A I went through it a few weeks ago.

Q You made no changes to it at all, did you, sir?

A There is no -- nothing that I could see to change.

Q All right.

A You are misquoting me.

Q Doctor, I thought we just established you said the question and answer --

A You're playing a game and misquoting me. If you want me to try explain so we can get to the truth, I would be happy to. Otherwise there is nothing I can do.

MR. WEBER: I object to that and move to strike the answer.

THE COURT: Sustained with regard to the doctor's last comments.

Q BY MR. WEBER: Now, Doctor, you believe there is no safe level of tobacco use, don't you?

A No. I don't believe there is any safe level of

tobacco use.

Q You believe there is no absolutely safe level of the use of alcohol, don't you?

A I am not so sure of that. If you want to quote what I said in the deposition, remember that it was in a different context, and it was a couple months ago.

Q Well, have you changed your opinion on whether or not there is a safe level of the use of alcohol in the last two months, Doctor?

A That question wasn't asked that way. The deposition -- if you are going to use my answer in the deposition to the answer to that question, you're confusing at least me.

Q Did you or -- did you not state at your deposition, Doctor, that you tended to lean to the camp that zero alcohol consumption was the only absolutely safe one for any given individual?

A No, I didn't say that.

MR. WEBER: Could I show the witness that to refresh his recollection, your Honor?

MR. BELLI: What page is that.

MR. WEBER: On page 75, Mr. Belli.

THE COURT: When somebody asks you a question, we will try to make sure we give you an opportunity to answer. Wait until they finish the question, and only answer that question, and then we'll do it question and answer.

Proceed.

Q BY MR. WEBER: Now, does that refresh your

recollection as to when you made that statement in your deposition?

A Would you read the statement as I made it in the deposition again, please?

Q Let me ask my question.

A I have forgotten. Will you read it to me?

Q I thought I just showed it to you.

A I think it would be useful to read it so we both agree what is there.

Q Let me show you again, Doctor.

MR. WEBER: Showing page 75 for the record --

MR. BELLI: Page 75?

MR. WEBER: Yes, sir.

Q BY MR. WEBER: Do you recollect having stated at your deposition that you tended to lean to the camp that zero alcohol consumption was the only absolutely safe level for any given individual?

A I said I tended to lean to that camp, not that I believed it.

Q The question, I think, if we go back, Doctor, would show that I asked that specific one.

Now, Doctor, don't you also believe that, if a person is chosing between wanting to smoke tobacco or use LSD, he would be well advised to use the LSD?

A If we are talking about a fully-informed adult, knowledgeable person, who knows all the risks and benefits, knows the right way of doing it, yes, I think they would be much better off using LSD than tobacco.

Q How about cocaine?

If I had a choice -- excuse me -- I don't mean "I."

If a person had a choice on whether he was going to smoke cigarettes or use cocaine, would he be well advised to use cocaine?

A Use cocaine by what route and what dose? I can't answer a general question like that.

Q I am not that familiar with the route. I think it has something do with the nose on occasion.

Let's assume that, Doctor.

A I think they should not use the cocaine because it's quite illegal right now. It's going to be enforced.

Q LSD was illegal, too, was it not, sir?

A You were asking that not in -- I don't understand the context that you're asking these hypotheticals in.

Q That is a fair comment.

I am just trying to understand your viewpoint about drugs. We've established so far, if a person has a choice between smoking cigarettes and using LSD, you think he would be well advised to use the LSD.

A With the caveats that I added.

Q If he was informed about each, correct?

A That's right.

Q My question is -- let's put LSD aside and address cocaine. Let's say a person wants to make a choice about whether he should smoke or use cocaine.

Would he be well advised to use the cocaine

instead of smoking the cigarettes?

A I think it would be fifty-fifty. They are both equally dangerous.

Q That is a close call.

A That is a close call. They are both very seductive drugs.

Q How about marijuana, if somebody wanted to decide, "Should I become a marijuana smoker or a cigarette smoker," is that a close call, too?

A I think marijuana -- we don't know enough about either one. I don't think they should use either one. It's different than LSD. We know a great deal about LSD, its safety, its risk. We don't know enough about marijuana

Q Let's talk about the pharmacology you referred to in your direct examination, if we could, all right?

A Yes.

Q Pharmacology and another term you used, psychoactivity, relate to the effects on the nervous system or the brain of various kinds of drugs, correct?

A That's right.

Q It's not -- strike that.

You can get a psychoactive reaction in the central nervous system and the brain from other things other than drugs?

A Yes.

Q You can get psychoactive reactions in the central nervous system and the brain from different types of food stuffs?

A I guess so. I don't know what you might be referring to.

Q You can get psychoactive reactions from the nervous system and brain from different types of activities, can you not?

A Yes.

Q One type of food stuff that you can get psychoactive reactions in the brain and nervous system from is chocolate?

A Right.

Q Coke, you can, too?

A Yes.

Q You can get psychoactive reaction in the central nervous system and the brain from caffeine as well, can you not, sir?

A That's right.

Q You can also get psychoactive reaction by standing in front of a large audience to speak, can you not, Doctor?

A Yes, you can.

Q You can get psychoactive reaction being in an airplane then taking a parachute jump?

A Yes.

Q I suppose you can get one by asking a witness questions or being the witness answering questions?

A Yes.

Q How about watching an exciting football game, would you get psychoactive reaction?

A Correct.
Q How about when you turn on the cold shower in the morning, you get psychoactive reaction?
A Right.
Q Assuming you you go into it.
Q How about smoking, you get a psychoactive reaction?
A Yes.
Q It releases the endorphins?
A Yes.
Q It can lead to an increase in adrenalin as well?
A Usually.
Q Performing intellectual exercises like taking a test that has a reaction on the brain?
A Yes.
Q Are you aware of the half-life of nicotine?
A Yes.
Q What is it?
A Sixty to ninety minutes, a variable number.
Q What does half-life mean?
A It's the time it takes for the level in the blood of a drug to drop to one-half of its current level.
Q Given that type of half-life -- according to you in any event -- which you said is sixty to ninety minutes, the effect of the nicotine in the blood would reduce itself down to practical nothingness within a matter of hours, correct?
A Depending on the the level you start with and depending on how you want to define practical nothingness.

Q Half-life doesn't depend on the level you started with because whatever level you start with within that period of time it's down to half, correct?

A That's right.

Q So, when you just said "depending on what level you start with," it isn't really relevant to the question?

A We are misunderstanding each other perhaps.

Q My point is this --

MR. WEBER: If I could make a mark on the board, your Honor, to illustrate --.

THE COURT: Just for illustration.

Q BY MR. WEBER: Let me make it quickly. Then I will go back and ask.

(Illustrating)

Let's assume that is one and this unit here would be one-half and --. Just to make sure everyone understands, including me, if we assume that one is a level of some substance.

All right?

A Yes.

Q When that substance's half-life is expired, the level would be down to half of what it was formerly?

A Correct.

Q Within the next half-life, it would be down to half of what it was at that time?

A Correct.

Q So that, regardless of what number you start with, that half-life reduction down to practical nothingness

comes out the same, does it not, Doctor?

A How do you mean practical nothingness? I don't understand the question.

Q That is to say when we get to the point we get a level that is immeasurable.

A That is hard to answer if you talk about nicotine, because nicotine is one of the most equisitely sensitive potent drugs. One microgram per kilogram, a millionth of a millionth of a gram is enough to cause activity at that third level there, whether it's nothingness or not, really depends on the amounts.

If -- I have data on that if you want to get into it.

Q Let me ask this: In terms of practical effect and psychoactivity: Isn't it a fact that, after one stops smoking, we go through a series of half-lives that, within a matter of hours, there is no more activity from the nicotine?

A Oh, our data would say you are absolutely wrong in that assumption. I can present the data from experiments done in my lab if would you like to hear it.

Q Your position is then that, within a matter of hours after one uses tobacco, the psychoactivity is not reduced to a normal state?

A No, I am not saying that.

I am simply saying that the tobacco smoker who is smoking two packs a day who, when they go to bed at night, has a level as your "Time 1" on this of fifty -- say forty say, forty nanograms per milliter of blood, that person, when they

wake up eight hours later at your third point has a level of ten nanograms per ml of nicotine in their morning blood before their first morning cigarette.

Whether that ten nanograms per ml in the blood has any psychoactivity, has any effects on function, nobody knows. One has to assume that it does until proven otherwise that it doesn't.

Q Let's stick with what we do know.

Based on what you do know, if a smoker goes to bed and wakes up in the morning, the level that he has in his system is not proven to have an psychoactivity effect, correct?

A It's proven to have an psychoactive effect in the sense, if they have a lower level than that, they are even more driven to light up a cigarette quicker. It must be having some effect that allows them to at least brush their teeth and maybe do something else before they light a cigarette.

Q There are things that may cause a a person to a cigarette apart from whether or not there is a couple nanograms grams of whatever in his blood serum, correct?

A That's right.

Q It's a learned habit to a degree, isn't it?

A Of course it is.

Q So, when you say "must be having an effect because a person may want to light a cigarette," that doesn't necessarily follow, does it, Doctor?

A The precise constellation of causes cannct be

nailed down one way or another; but, you can't eliminate any of the causes by the same token.

Q Doctor, even under the way you would analyze the half-life, within a matter of two days, the nicotine in the bloodstream would be reduced?

A Of course, yes.

Q As a matter of fact, what do your studies show, one day?

A It depends on how sensitive the instrument is that you're measuring it. We now have a masspectrometer that can measure a pyelogram, which I am sure we'll be able to measure nicotine at least forty hours or so after someone stops smoking. That is not the point. It's a measurement gimmick, really.

Q Let's put the gimmicks aside and focus on the realistic measurement of nicotine that might have an effect on human beings.

MR. BELLI: I object to the word "gimmick" and ask it be stricken.

THE COURT: I will ask counsel not to editorialize the question.

MR. WEBER: Your Honor, I thought that was the word he used.

THE COURT: I only admonish Counsel, not the witness. I understand that was the word he used.

Q BY MR. WEBER: Let's focus on the practical effect of the -- nicotine in the blood. Your studies show that, within a matter of one day, it's reduced to a level

where it no longer has a practical psychoactive effect?

A That's correct.

Q The knowledge that smoking has a pharmacologic effect is not knowledge that has occurred only in the past few years, is it, Doctor?

A It goes back some years.

Q It goes back at least twenty, twenty-five years, does it not?

A At least, yes.

Q Probably a good deal longer than that, correct?

A That's right.

Q It was discussed in great detail at the time of the 1964 Surgeon General's report was it not, Doctor?

A I would assume so. I am not intimately involved and familiar with that authority.

Q You mentioned the Surgeon General's report?

A The later ones. There are yearly ones. I don't keep track of which years, what's in it.

THE COURT: Let him finish the question before you interrupt.

Q BY MR. WEBER: You mentioned the Surgeon General's report on smoking in your direct examination.

A Yes.

Q The first one was the one issued in 1964?

A I assume so if you say so.

Q Do you know one way or the other?

A That is not something I find important keeping that milestone in mind.

Q Do you know whether or not there is an extensive discussion in the 1964 Surgeon General's report regarding whether or not tobacco was a habituating or an addictive substance?

A I don't recall that discussion, no.

Q So, as you sit here today as an expert in what you say is the addictive quality of tobacco, you don't know one way or the other whether or not the first Surgeon General's report discussed whether or not tobacco was an addictive substance?

A I am very familiar with the state of theory of addiction twenty years ago and feel that the field has made some progress in twenty years and that -- that is why I didn't bother to read it in preparation for this testimony. That is why I didn't cover it in a review chapter I am currently writing. I don't think it's that important.

It's last year that theory is, and data. This is 1985.

Q Do you know whether or not, in any one of the annual Surgeon General's reports since then, the Surgeon General has issued a statement revoking the judgment made in 1964 that tobacco is not particular different?

A That's not the way scientists refer -- I don't know of any statement revoking it, but there have been statements in many of the recent reports saying it's an addictive process.

Q Isn't it a fact that, in the recent reports, tobacco smoking is still referred to as a habituating process?

A I heard Surgen General Cooper on the radio Sunday say it was an addictive process.

MR. WEBER: Objection: move to strike.

THE COURT: The answer is stricken.

Q BY MR. WEBER: We are talking about Surgeon General's reports now, Doctor, not what someone may tell you on the radio, but in terms of formal reports of the Surgeon General, right, sir?

A Yes, sir.

Q Isn't it a fact that the Surgeon General's reports year after year after year have referred to tobacco as a habituating usage?

A If I could take a look at "The Changing Cigarette," which is one of the more recent reports, I could read for you, for the Court, a quote which I think that says the Surgeon General has changed his mind.

Q Are you able to answer my question one way or the other right now?

A The answer is --

Q What position was taken by the Surgeon General, Doctor, in the 1981 report; do you know?

MR. BELLI: I object to those old reports. I have no objection to the current reports.

MR. WEBER: I am sorry?

MR. BELLI: I object to the old reports. I have no objection to the now current, as of today, reports.

THE COURT: The 1981's an old report?

MR. BELLI: I object to them as being irrelevant, immaterial and incompetent if we show that the new reports have a different position.

THE COURT: I am going to ask the same question: You think an '81 is an old report?

MR. BELLI: Yes, if it's a changed position, day and night.

THE COURT: Okay.

Now, I do not know whether there's has been any change. I will ask counsel to ask whether there has been any change since the '81 report.

Before you go into it, we'll take our recess at this time, before you do so.

Remember admonition, ladies and gentlemen: Do not discuss the case among yourselves nor with anyone else, nor make up your mind about it until it's finally submitted to you.

We will see you in about ten or fifteen minutes.

(RECESS)

THE COURT: The record will reflect that everybody is present.

Are we ready to proceed?

MR. WEBER: Yes, your Honor.

Q BY MR. WEBER: Doctor, we were discussing before the break the Surgeon General reports, were we not?

A Yes.

Q I saw you reading through -- was it the '81 report during the break?

A I think at the '81 report.

Q The green-covered one?

A Yes.

Q There was an objection, as I recollect, about recent reports and not wanting to use older reports; do you remember that?

A Yes.

Q And let's look at the '83 report if we could. That is more recent than the green one, is it not?

A (No response)

Q I will ask whether you recollect this statement from Page 209 of the 1983 Surgeon General's report under the topic "Nicotine."

"A number of observations have supported the concept that nicotine is the major habituating agent in tobacco and tobacco smoke."

Do you recollect that, Doctor, "yes" or "no," sir?

A No, no.

Q Now, the fact of the matter is, Doctor, that referring to tobacco and smoking as habituating in 1983 is a repetition of the position taken by the Surgeon General in the first report in 1964, isn't it?

A Yes.

Q Indeed, in 1964, Doctor, reading from Page 350 of the 1964 report, did not the Surgeon General state, "In the medical and scientific terminology the practice (that is smoking) should be labeled habituating to distinguish it

clearly from addiction, since the biological effects of tobacco, like coffee, other caffeine containing beverages, betel morsel chewing and the like are not comparable to those produced by morphine, alcohol, barbiturates, and other potent addicting drugs."

Do you recollect that, sir?

A No.

I didn't read those reports. I don't read the Surgeon General's reports. I go to the primary sources for which those reports are written. Those reports are fine. I don't agree with them. I didn't read -- I can save us a lot of time. I haven't read any of those.

Q You said you read them on direct.

A I have read some of them. I didn't read all of them.

Q You just said you didn't read any of them. Now you said you read some of them. On direct, you said you read them all.

MR. BELLI: I object: That is argumentative.

THE COURT: Sustained.

THE WITNESS: I didn't read what you just read is the simple answer to your question.

Q BY MR. WEBER: Let's sum up this part: What we know now, at least with respect to the section that dealt with habituation and addiction in the 1964 report, that is the area you didn't read, correct?

A That's right.

Q That is the one area that dealt with what you

specialize in, correct?

A Correct.

Q Did you read the parts that deal with areas you didn't specialize in?

A I leafed through them.

Q Now, you said you didn't read the Surgeon General's reports, but you go to the underlying data?

A Right.

Q Is that because you find the reports unreliable?

A On the contrary, I just find them very dull reading.

Q You disagree with this one, do you not, the '64?

A Yes, I disagree with it.

Q I take it you disagree with the '83 when it refers to nicotine as habituating as opposed to addicting?

A I think the word "habituation" is a very vague word. I disagree with the use of the word.

I suspect the Surgeon General would. He would probably agree as to the meaning of the word "habituation," but it is a vague term.

Q Habituation has a different meaning in the medical science than addiction?

A I don't think so. I think both of them have a very blurry, fuzzy meaning.

Q They both have blurred and fuzzy meanings, but you don't take the position that, in 1964 when the Surgeon General wrote his report, that he thought they meant the same thing?

A Ask it of him.

Q You're not stating now that addiction and habituation were used synonymously by the Surgeon General in the 1964 report?

A I cannot speak for the Surgeon General. How could I?

Q You realize, in the 1964, report a clear distinction was drawn between habituation and addiction?

A I would disagree it's a clear distinction.

Q Let me read this to you and see if -- let me read to you, if I could, just to ask whether or not you think it's a clear distinction, that same section I just tried, and have you comment on that.

Is that all right, Doctor?

Again, from Page 350 -- "In medical and scientific terminology, the practice (that is smoking) should be labeled habituating to distinguish it clearly from addiction, since the biological effects of tobacco, like coffee and other caffeine containing beverages, betel morsels chewing and the like are are not comparable to those produced by alcohol, morphine or barbituates and other potent addicting drugs."

A I think --

THE COURT: There may be an objection, which I didn't hear.

MR. BELLI: Asked and answered. This is already read.

THE COURT: Overruled because the witness indicated that he seemed to have some question as to what some words

meant. Otherwise, it normally would have been asked and answered.

Answer the question, Doctor.

THE WITNESS: I would disagree with the conclusions in that statement.

Q BY MR. WEBER: In 1964, the Surgeon General stated that the distinction between addiction and habituation that was being drawn was a definition which was at that time accepted throughout the world as the basis for the control of potentially dangerous drugs, did he not?

A Are you asking me is that written?

Q Do you recollect that?.

No, I don't recollect it because I don't remember reading it.

Q Do you recollect when the Surgeon General, in 1964, based his determination on the criteria set up by the World Health Organization?

A It's quite probable that he did that.

As I stated earlier before the recess, things changed in the last twenty years about the nomenclature, the definitions at the world level and locally.

Q So that you don't find it unreasonable that, in 1964, the Surgeon General looked to the criteria of the World Health Organization?

A No.

Q You find it reasonable for him to do so, correct?

A That is probably all he had to go on in 1964.

Q The fact of the matter is, right now, the current

World Health Organization criteria don't classify tobacco usage as drug dependency?

A It doesn't say what department of the World Health Organization you are talking about.

If you talk about ICD-9, you're right. I made a mistake there. If you are talking about the World Health Organization commitees, things are in a state of flux.

Q I am not talking about committees. I am talking about what the World Health Organization talks about in the Classification of Diseases, number nine. It's the most recent statement of classification of disease.

A Right.

Q That does not include tobacco within the definition of drug dependency, does it?

A I was wrong. I thought it did. I misspoke.

Q You referred earlier, Doctor, to the classical definition of addiction, and said that, because of the classical definition which limited it to drugs, potato chips and those types of other things to which people commonly use the word addiction really aren't addictions, correct?

A It's, I think, a misuse of the classical definition is all I have been saying.

Q The fact of the matter is, Doctor, if we go back to the classical definition of addicition, tobacco doesn't satisfy that either, does it?

A In the current authoritative medical texts, it is classified as an addictive drug.

Q The classical definition of addiction, the one

used by the World Health Organization and other standard setting bodies internationally doesn't use tobacco as an addiction, does it?

A The American -- no, it doesn't.

Q Now, sir, you also stated that there are many factors that go into the matrix about whether or not a person can quit smoking: genetics, body chemistry, friends, work, relatives, correct?

A That's correct.

Q You stated all of these could conspire to make the person a victim, unable to make a decision, correct?

A It can do that, yes.

Q Didn't you say that speaking about the deranged state of the smoker?

A I don't remember here using the word "deranged."

Q Do you think smokers are deranged, Doctor?

MR. MONZIONE: Argumentative?

THE WITNESS: No, I don't think they are deranged if I understand how you use the term. I am only questioning what you mean by deranged.

Q BY MR. WEBER: You don't remember having used it on direct by the "deranged state of the smoker"?

A I might have said deranged or disorganized or dysfunctional. If I said "deranged," with -- I mean, grossly disorganized almost in a psychotic intensity. I either misspoke, or didn't use it.

Q We'll let the record speak to that.

MR. BELLI: I think he said deranged chemical --

THE WITNESS: I did say deranged chemical --

THE COURT: No. There is no question pending.

When someone is talking, I will ask you not to interrupt.

I did not know if that is an objection.

MR. BELLI: Yes, that is an objection. He's misquoting the witness.

THE COURT: Ladies and gentlemen, your twelve memories -- fourteen now, but twelve eventually -- will make the decision as to whether someone said something or not. If you have some question about it, we have a method of handling it. That is why we have a reporter if it's important.

However, I frankly, Counsel, don't recall one way or the other. I remember hearing the word, but it may not be used in the context of the question. If the word is used out of context, it is your knowledge of the appropriateness of any question related to and the relevance.

Q BY MR. WEBER: You stated earlier regarding your understanding of addiction, Doctor, that people don't really know they're addicted until they find out they can't stop.

Right?

A That's right.

Q So, if I understand it, if you try to stop and can, you're not addicted right?

A No.

If you try to and can, but then later on restart, that is the test.

Q Let's take someone who smoked for a number of

years and quit -- all right, sir?

A That's right.

Q -- is irritable for a day or two and doesn't smoke; six months later you are called in, Dr. Reese T. Jones, to give an opinion: Is this man addicted?

Is he?

A No.

Q He might be the next day if he starts again?

A That's right.

Q How about someone who is chain smoking, Dr. Reese T. Jones is called in to give an opinion as to whether he's addicted, a person smokes a pack and a half a day; is he addicted?

A I would have to know whether the person has tried ever to stop.

Q Let's say he tried to stop a few years ago, realized he liked the taste of cigarettes and wanted to keep doing it.

Is he addicted?

A I would be inclined to -- if -- yes.

Q What we are dealing with, Doctor, is a self-fulfilling definition, are we not?

A To some extent, I suppose.

Q So that if someone wants to be addicted, all they need to do is say, "I can't stop"; and, if you don't want to be addicted, all you have to do is stop, and you're not.

MR. BELLI: That is argument: objection.

THE COURT: Overruled.

THE WITNESS: You're quite right.

MR. WEBER: Doctor, I have no further questions.

REDIRECT EXAMINATION

BY MR. BELLI:

Q I have a number of quesitons to clear up.

What did you say about a person being deranged when they smoke or stop smoking; did you mean they were mentally deranged, or did you -- or the chemistry was deranged?

A I sometimes start talking too fast, and my mouth runs ahead of my brain.

What I meant, I am quite sure, was that they were biologically, biochemically deranged; that is, their hormones were not in balance, their neurotransmitters were not in balance, not that they are gravely psychologically deranged in the sense that term is usually used.

Q Why is it that that a person can't stop smoking?

MR. WEBER: Object to that, your Honor: There is no context to it.

THE COURT: I am going to sustain it. I am not sure how it is relevant to the cross-examination.

Q BY MR. BELLI: If a person is addicted, he can't stop smoking, right?

A That is part of the definition, yes.

Q Let's take that part of the [deposition]. What is it that happens in the body, the blood, or wherever to make it impossible or difficult in some people to stop smoking?

MR. WEBER: I object, your Honor. There were no questions about blood chemistry or anything else.

THE COURT: Sustained.

Q BY MR. BELLI: What is that makes it impossible for some people and most difficult for others to stop smoking?

A They have adapted to a life where there is a significant amount of nicotine in their body, where there is a significant amount of their life is involved with obtaining, smoking, enjoying the cigarettes; and, if that is taken away, there are derangements -- not mental derangement -- functional derangements. Something is left that occupied six, seven, eight, ten hours of their day.

Q Some people who try to stop smoking and are successful, transitorily, for two months or two years, if they start back two years later, would you say they were addicted; and, if so, why?

A The duration of addiction probably is forever. If circumstances two years after someone has essentially stopped are such that it encourages smoking again, it becomes more rewarding than not smoking, becomes more pleasurable than not smoking, they start smoking again. We call it addiction.

Q What World Health Organizations now -- withdraw.

Is the definition of addiction and the studies of addiction going on every day in tobacco smoking?

A There is a tremendous research activity.

Q Is there new laboratory evidence being found daily?

A I think -- yes. Yes.

Q Will you tell the ladies and gentlemen of the jury the unequivocal position of the Surgeon General right now, today, as to whether cigarette smoking is addicting?

MR. WEBER: Let me object it's --

THE COURT: Ground?

MR. WEBER: The grounds are it's going to be based on an incompetent foundation.

THE COURT: I am going to sustain the objection on the basis you haven't laid a foundation.

If you're going to talk about the Surgeon General's report, I will allow that question. That is not the way the question was phrased.

Q BY MR. BELLI: When is the last Surgeon General's report in print?

A I am not sure when the date of the last one, the most recent one --.

Q Answer this "yes" or "no" and don't answer it any more definitively: Do you have an opinion as to whether the Surgeon General has an unequivocal position now as to whether --

MR. WEBER: Objection.

THE COURT: Let him finish the question.

MR. WEBER: Can I approach the side bar?

THE COURT: Yes, you may.

(Whereupon, the following proceedings were held at the side bar outside the hearing of the jury:)

THE COURT: Mr. Belli, I guess what you want him to do

is quote his position -- the Surgeon General's position on the radio the other day?

MR. BELLI: If he knows what the position is, talking in school or among his researchers, or where he found out what the Surgeon General's opinion today is.

MR. WEBER: Number one, absolutely classic hearsay. It's not a government report. He's going to say, "The Surgeon General told me something." I don't have the Surgeon General here to cross-examine.

Number two, we are talking about the Surgeon General's reports. The Surgeon General speaks through his reports. We've established his reports say it's not addictive. He can't say, "I had a side conversation with him, and he really means to say something else."

THE COURT: The hearsay objection is certainly -- seems, on the surface, appropriate.

Do you have an exception? You are asking not what what he said in the report but what he said outside that.

MR. BELLI: I am asking the statement of fact: What is the Surgeon General's at the present time, referring to whether cigarette smoking is addictive.

THE COURT: It calls for hearsay. Is there an exception?

MR. BELLI: Yes, I think there is because he went into the former reports as to the Surgeon General's opinion as expressed in his reports now. There has been new evidence introduced every day as the witness has testified.

The new evidence now is that it is definitely

addictive, and that is a position of the Surgeon General.

THE COURT: What is the exception?

MR. BELLI: In answer to the cross-examination as to what the Surgeon General's opinion, is I think it would be most unfair if we know that something is true now, and that the jury is left with the impression that the old report is the truism.

THE COURT: The objection is sustained.

I will instruct counsel not to go into or ask questions relating to what the Surgeon General has told this witness in any form without checking at the side bar.

(Whereupon, the following proceedings were held at the side bar within the hearing and presence of the jury:)

Q BY MR. BELLI: Doctor, the National Institute on Drug Abuse, Addiction and Research Center, is that part of the Health and Welfare Department of the United States Government?

MR. WEBER: Objection, your Honor: There were no questions asked about the National Institute on Drug Abuse on cross.

THE COURT: Was there anything asked about that, Mr. Belli? I don't recall anything.

MR. BELLI: Asked about -- withdraw.

Q BY MR. BELLI: Doctor, do you base part of your judgment of current evaluations of addiction of cigarette smoking on anything in the National Institute of Drug Abuse, Addiction and Research Center.

MR. WEBER: Same objection, your Honor.

THE COURT: Sustained.

Q BY MR. BELLI: What do you base your prejudgment that cigarette smoking is addicting, among other things?

A My current judgment is based on the latest authoritative evidence that appears, not quite daily but almost weekly, in the scientific journals. There are a number of pivotal reports in the last few months.

Q Can you name one of them the most late and most authoritative?

A I think one of the most important reports comes out of the National Institute and Drug Abuse, Addiction Research Laboratories in Baltimore. That is the main government research center on addictive disease.

Q Is that part of the Johns Hopkins University School of Medicine?

A They have an affiliation with the Johns Hopkins School of Medicine.

Q Is that part of Health, Education and Welfare?

A It's all supported under that general egis, yes.

Q What is their very latest, as of this month, determination on addiction?

MR. WEBER: Objection, your Honor.

THE COURT: Sustained.

Q BY MR. BELLI: What do you base your opinion on with reference to them?

MR. WEBER: Objection: That is vague. I can't tell -- I am not sure what he's asking.

THE COURT: I don't know what "them" means.

Q BY MR. BELLI: Doctor, you said that you based your opinion as to the latest on addiction on an article in the National Institute of Drug Abuse, Addiction and Research Magazine. Is that right?

MR. WEBER: Objection: It is not what the doctor said. Mr. Belli is testifying himself.

THE COURT: Sustained.

Q BY MR. BELLI: Doctor, do you base your judgment and opinion that cigarette smoking is addictive on what?

A On a number of pivotal recent papers that have come out within the past few months dealing with the specific issue of tobacco and nicotine addiction.

Q Are any of them having do with the National -- Health, Education and Welfare?

A Many of them do in the sense that that is the organization that supports a bulk of scientific tobacco and nicotine research in the United States.

Q Did you use or depend upon the article "Abuse Liability in Pharmacodynamic Characteristics of Intravenous and Inhaled Nicotine"?

MR. WEBER: Same objection.

THE COURT: Sustained.

Q BY MR. BELLI: Did you base your opinion and judgment on any of the latest articles from the Health, Education and Welfare --

A Most of the -- most the articles that I think of as important pivotal ones come from that source of support.

Perhaps the most outstanding one that I think has

caused many skeptics to reconsider is one that recently came out of the Addiction and Research Center in Baltimore, published in the Journal of Pharmacology and Experimental Theraputics a few months ago. It's a key article.

Q What did that say?

A It concludes it conclusively --

MR. WEBER: Objection to what it says.

THE COURT: Did you base your opinion on this, Doctor?

THE WITNESS: Truly, I based my opinion, to some extent, on this.

THE COURT: The objection is overruled.

Q BY MR. BELLI: Did your Honer overrule that?

THE COURT: I overruled the objection. You finally got through to him.

Q BY MR. BELLI: Let me not do like you are accused of doing, and I do, and overlap.

What was your opinion?

MR. WEBER: The last question wasn't what his opinion was.

MR. BELLI: Let's read the question. You've succeeded in confusing even me.

THE COURT: Doctor, do you remember what the question was?

THE WITNESS: I would appreciate if someone would read the question.

THE COURT: The one that gets punished by this procedure is the court reporter.

(Whereupon, the record was read.)

MR. WEBER: Your Honor, I have an objection: He can't say what the article says. The author of the article isn't here to be cross-examined.

THE COURT: Doctor, tell us what your opinion was that -- if it was based on any particular facts, you may state generally, not specifically, what the article stated; but generally you relied on it and what it said.

Again, ladies and gentlemen, the witness -- you're not to accept the witness' comments for the truth of what the article said, but only for the reliability of the opinion expressed by the witness.

Proceed.

THE WITNESS: I will try and explain why I cite that particular --

Q BY MR. BELLI: Do you want to see the article?

A Is it proper?

THE COURT: Go ahead.

THE WITNESS: I will try to explain why I cited that.

Understanding tobacco dependence is like a jigsaw puzzle, you have a few pieces here and a few pieces there. This particular article is the end of a series of studies started about five years ago about people associated with the Addiction and Research Center. They put some of the final pieces into the puzzle.

The pieces have to do with the specific role of nicotine. How does nicotine compare with other drugs that are unequivocably, by the World Health Organization and everybody else, considered addictive drugs, when you give the nicotine

in the form of injections, IV or smoke, to people who have had experience with tobacco addiction, with other drug addictions, who know drugs. This was all a very tightly controlled study with all the proper controls that these scientists would demand, published in a prestigious journal where editorial reviews are very rigorous. It fitted this piece in.

My understanding of the message from that article -- I won't quote from it -- but my understanding from the message in that article is that, when you give to people who have had experience with cocaine and other drugs, nicotine, whether given intravenously or given by smoked routes, that produces similar sort of effects -- judged the drugs to be very, very similar.

It's a procedure that is the standard, acceptable one to assess drug dependence liability by the Food and Drug Administration, by our U.S. Government and by other world level organizations.

When subjected to that test, that procedure, like it was a new drug we didn't know anything about -- it just came off the shelf of some drug company; you put nicotine into that procedure; you put tobacco into that procedure -- it looks like a drug of abuse.

Sorry. I am so wordy, but that is the conclusion.

THE COURT: Go ahead, Mr. Belli.

Q BY MR. BELLI: Who is Jasinski? J-a-s-i-n-s-k-i Donald Jasinski?

A Dr. Jasinski is someone who, I would imagine, for

twenty years, has been involved with the assessment of the addiction liability of all types of drugs abused, legal drugs, new drugs. Dr. Jasinski is one of the senior people in the world who performed this study, signed his name as author to it as one of the three authors, and I would assume, from knowing him quite intimately, would support all the conclusions that are in that paper.

Q Did he contribute to this article?

A He was one of the authors of the article.

Q You said something about LSD and smoking.

Did you make any suggestion as a choice that one should choose LSD instead of smoking?

A The statement that I made --

Q Keep your voice up.

A The statement that I made was presented, I fear, a little out of context in that, when I was presented with a clinician's dilemma --

MR. WEBER: Your Honor, I object: The question was whether he made the statement. Now, we are getting commentary.

THE COURT: Sustained.

Listen to the question, Doctor, and try to answer it.

Q BY MR. BELLI: Doctor, did you make any suggestion that one should choose LSD instead of smoking?

A Yes.

Q What did you suggest?

A I suggested that, if one is talking about the

wise use of LSD, keeping in my own mind all the dangers of LSD and the risks and the problems it poses, I think, on balance, someone would be better off using LSD wisely -- I mean, occasionally, intermittently -- than taking up smoking or continuing smoking, in the case of the statement I was asked to respond to.

Q How about William Pollen, who is he?

A Dr. William --

MR. WEBER: Objection, your Honor: Beyond the scope of the cross.

THE COURT: Sustained.

Q BY MR. BELLI: Did you rely on William Pollen in the National Institute of Drug Abuse and Research as to the addictive qualities of tobacco smoke.

MR. WEBER: Objection: He's testifying.

THE COURT: Sustained.

Q BY MR. BELLI: Now, when someone wakes up at night and has some -- smokes a cigarette, what is happening to him physiologically? I am talking about someone who has one to three packs a day.

A If it's someone who wakes up out of a sound sleep with an urge to smoke, it's the body's response to a deficiency, a lack of nicotine.

Q There was a part of page 43 that wasn't read, I would like to read this to you. Page 43 was read down to line 20. I would like to read beyond that.

(Reading:)

"Q Whatever withdrawal symptoms exist

in stopping smoking for a particular individual, they are certainly not on the same caliber of withdrawal symptoms for morphine or heroin addict, are they?

"A On the contrary, that's a common misconception. It depends on dose.

"At lower doses of opiates use, morphine or heroin or any other opiate, at lower doses there is more similarity than you might think to tobacco in the withdrawal. The classic opiate withdrawal, if that is what you're talking about, with vomiting, wretching, diarrhea, goose flesh, and shakes, and irritability, no, you don't see that with tobacco.

"But with lower doses of opiates, and commonly, not always, the addicts come in restless, irritable, can't sleep, feelings of hot and cold, autonomic disturbance, really minimal symptoms, and it's not unlike what one sees in some tobacco smokers; not all tobacco smokers. On the other hand, not all opiates users show it, either.

"So, there is a lot of similarity on a lot of the symptoms and signs."

Then there was another page --

MR. WEBER: I object to this, your Honor.

THE COURT: Give a page and line that you want to read.

MR. BELLI: I think it's 75, 19 to 27, through 27.

MR. WEBER: I've no objection if he wants to read it.

THE COURT: All right.

Q BY MR. BELLI:

(Reading:)

"Q If I can go back to the criteria you gave for determining how much alcohol makes one an alcoholic, I take it that you don't have a precise amount of alcohol there, but it depends upon the behavior that results from the consumption of the alcohol?

"A The behavior that's associated with it, not necessarily results directly from it. Yes. It's an individually-determined figure."

Now, with smoking, is it an individually-determined figure as to the particular individual?

A Yes.

Q Some people can stop easier than others?

A Very much so.

Q Some people can't stop? That is a question.

MR. WEBER: Objection: He's testifying again. It's --

THE COURT: Sustained.

Q BY MR. BELLI: With some people, do they stop?

A Some people can stop surprisingly easily. Some people cannot stop even though it's killing them.

Q You were asked about this psychic reaction when you stand in front of an audience, you get some kind an psychic reaction when cross-examining another doctor?

A I was experiencing it today.

Q But you didn't get cancer?

MR. WEBER: Objection.

THE COURT: Sustained.

Q BY MR. BELLI: Do you have an opinion as to whether cigarette smoking is causative of carcinoma of the lung?

MR. WEBER: Objection, your Honor --

THE COURT: Sustained.

The question is improper. You know it. I will ask you not do it again. If I ask you the third time this will be a problem.

Q BY MR. BELLI: That is all.

Thank you very much.

THE COURT: Anything additional?

MR. WEBER: Two or three, if I could, your Honor.

RECROSS-EXAMINATION

BY MR. WEBER:

Q With respect to what makes a person an addict or not essentially depends on whether he says he can stop or not, correct?

A That is part of definition, yes.

Q If the person goes ahead and stops, he's not an addict, right?

A See, you and I are using different language.

When you say what makes the person the addict, you're talking about the definition. I am thinking about the

mechanisms, what is going on in the mind.

Q Let me clear up my language. The definition of addict, as you use it, with it carries the connotation that, if someone quits, he's not an addict?

A That's a part of DSM III diagnostic.

Q He's not an addict unless he starts?

A Right.

Q On Monday, he's not addict, but Tuesday he might be?

A Right.

Q If he's smoking now and enjoying it and doesn't want to quit, he's not addict, right?

A That's right.

Q But if he's smoking now and tells somebody he wants to quit but can't, he is an addict?

A That's right.

Q Nothing further.

FURTHER REDIRECT EXAMINATION

BY MR. BELLI:

Q There is physiological make up of some people that prevent them from quitting, right?

MR. WEBER: Objection: beyond the scope of the recross.

THE COURT: Sustained.

MR. BELLI: This is one further thing if we approach the bench.

(Side bar conference not reported.)

(Whereupon, the following proceedings were held in the chambers of the Court outside of the hearing and presence of the jury:)

MR. BELLI: I would suggest, again, that we have, on cross-examination, it stated that there is an opinion of the Surgeon General with reference to addiction. I think that, under Section 1280, even if it's hearsay, we can ask the witness if he relies on the Surgeon General's most recent position for the support of his opinion that cigarette smoking is addictive.

THE COURT: Mr. Belli, do you have anything in your offer of proof other than the fact that the witness heard it on the radio?

MR. BELLI: I don't care how he heard it.

THE COURT: You have nothing except --

MR. BELLI: Nothing further than that is his knowledge now that he knows from the Surgeon General on public radio that wouldn't be disseminated throughout the courtry, every state in the United States, that the Surgeon General says it's addictive.

THE COURT: That's not under 1280.

Request denied.

MR. WEBER: Can I make a motion at this time.

I want to speak slowly, because I am concerned now. I want to make a motion -- I am not sure of the exact nature of the California rules in this respect, so I hope

everybody bears with me.

I want to make a motion Mr. Belli be held in contempt of court for the question about cancer. It was unconscionable. It was precisely violative of the Court's order this witness be limited to certain areas. It was done solely for the purpose of influencing the jury. It's not justified.

THE COURT: There is no question in my mind Mr. Belli deliberately and willfully violated the order of the Court.

MR. BELLI: I never --

THE COURT: We'll take up all questions of contempt at the end of trial.

MR. BELLI: There was nothing ever said about cancer standing in front of the audience, Judge. He went into it on cross-examination.

THE COURT: Let's proceed.

MR. BELLI: It was relevant --

(Whereupon, the following proceedings were held in open court within the hearing and presence of the jury:)

MR. BELLI: Nothing further.

THE COURT: Anything further Mr. Weber?

MR. WEBER: No, sir.

THE COURT: Unless I hear otherwise, the witness is excused.

Hearing nothing, the witness is excused.

MR. MONZIONE: Let me make an inquiry with respect to this witness as far as his being excused. In light of the

motion pending Monday and this most recent question that was just --

THE COURT: If you want to call him back, that is a different story. That doesn't mean -- he's excused from his testimony here.

If you wish to call him back, that is something else.

The witness is excused.

Counsel, may I see you for a moment at the side bar?

(Side bar conference not reported.)

THE COURT: Ladies and gentlemen, we'll take our recess at this time. We will not be in session on Monday morning. I will let you know this afternoon for how long. I have another matter that is going take a little while at nine o'clock, a criminal matter.

Then counsel and I have -- are going to get together on probably a lengthy hearing. I will let you know before we leave today, after I discuss it with counsel this afternon.

I will ask them to stay for a moment for scheduling purposes. I have the matter at four o'clock I told you about yesterday.

Remembered the admonition -- we will see you at 1:30 today -- Do not discuss the case among yourselves nor with anyone else nor make your mind about it until it's finally submitted to you.

(Whereupon, the noon adjournment was

taken until 1:30 p.m. of the same day.)